DOCUMENT RESUME

ED 375 703 HE 027 787

AUTHOR Bednash, Geraldine
TITLE Health Care Reform: Implications of the President's Plan for Nursing Education.
PUB DATE 94
NOTE 16p.; Originally a speech given at the 1994 Annual Meeting of the Southern Council on Collegiate Education for Nursing.
AVAILABLE FROM Southern Council on Collegiate Education for Nursing, 592 Tenth St., N.W., Atlanta, GA 30318-5790.
PUB TYPE Viewpoints (Opinion/Position Papers, Essays, etc.) (120)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Costs; *Educational Change; *Federal Legislation; Health Insurance; Higher Education; Medical Services; Nurse Practitioners; Nurses; Nursing; *Nursing Education; Physicians
IDENTIFIERS *Clinton Administration; Health Care Economics; *Health Care Reform; Nurse Clinicians; Nurse Educators; Nurse Patient Relationship; Nurse Physician Relationship

ABSTRACT

This paper discusses factors emerging from the health care reform movement that will shape health care service delivery in general and nursing practice and education in particular. First, cost concerns will increase moves toward managed competition which will, in turn, create changes in service use patterns. These patterns seem overall to tend toward decreased demand for professional nursing staff. These patterns will also eventually see nurses emerge with markedly different employment roles. One such role is likely to be a reshaped clinical nurse specialist role with nurses sometimes substituting for physicians. The current discontinuity between nurse practitioners' education and hospitals' desires to employ advanced practice nursing clinicians has seen a growing trend toward on-the-job training for acute care practice or toward development of acute care nurse practitioner training programs. One of the most important effects of health reform on nursing may be the need to define workforce supply in very different ways resulting in different workforce management and planning. Finally the paper argues that current and future medical research in genetic engineering will dramatically change health care decision-making, a change which nurses must be educated to handle. (JB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

HE

ED 375 703

Health Care Reform

Implications of the President's Plan for Nursing Education

Geraldine Bednash, Ph.D., FAAN

HE 027 787

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

SREB

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC).

 BEST COPY AVAILABLE

Geraldine Bednash, Ph.D., FAAN, Executive Director, American Association of Colleges of Nursing (AACN), gave the keynote address at the 1994 annual meeting of the Southern Council on Collegiate Education for Nursing. *This presentation was written by Geraldine Bednash in her private capacity. No official support or endorsement by AACN is intended or should be inferred.*

BEST COPY AVAILABLE

Health Care Reform: Implications of the President's Plan for Nursing Education

Geraldine Bednash, Ph.D., FAAN

Clearly, the reform proposal offered by the Clinton administration has had sweeping and dramatic effects on the whole climate surrounding health care debates. The proposal's implications for the nursing profession warrant our attention and thought.

Access
Coverage
Competition

The administration's plan has several key elements. First, and foremost, is the requirement that there be universal access to health services for all U. S. residents. In fact, this year the President made very clear his belief that this was a non-negotiable element of health care reform when he literally brandished the "Veto Pen" in his State of the Union Address.

Second, the Clinton plan focuses on decreasing costs through managed competition initiatives and regional alliances. The administration has adamantly proclaimed a desire to have a plan that allows consumers a choice in selecting health care providers, and focuses on increasing the quality of the care and attempts to make receiving health care simpler.

The debate on reform of health care is escalating, however. For instance, Pete Stark has said he would rather "throw up" than vote for the Clinton plan. Recent moves by business leaders and some unions, have created an atmosphere of uncertainty about the reform process and what types of legislative changes will occur in the final half of this congressional session. For many watching the process, there seem to be very low expectations for the reform process in this congress. Pessimism reigns supreme. The conventional wisdom is that since this is an election year, insurance reform is probably the most dramatic reform that can be expected. The insurance companies have clearly been targeted by Mrs. Clinton in her efforts to expand support for the administration's proposal. Mrs. Clinton was quoted in the *Washington Post* (February 4, 1994) as saying, "The financing system is becoming the tail that wags the dog. The insurance companies are in charge and pick and choose whom they cover." She further castigated the insurance industry as a "private sector" health industry "rife with fraud, waste, and abuse." To some extent, the insurance industry may have been targeted by the administration because the public at large has great mistrust of insurers. Stories about exclusionary policies and practices fuel the belief that some kind of reform of the current insurance system is, at a minimum, necessary.

But while much attention has been placed on the administration proposal, numerous other proposals have been developed, including a single payor proposal—from Representative McDermott of Washington State to the extremely conservative medical IRA bills of the Republicans. The managed competition proposal of the Cooper and Grandy Bipartisan Group's health reform bill would deliver care coverage through accountable health plans that employees could join. In fact, the Cooper/Grandy bill has recently received widespread affirmation from several important groups including the Washington Business Group on health. So, clearly, the issues surrounding health care reform are not going to be easily resolved. No one has a crystal ball about what will be passed in this year. And it should be remembered that this is an election year. The Congress is very aware of the fact that as soon as it makes its decisions, members will have to return home to an electorate that may or may not be pleased with the legislative outcomes.

Cost
Quality
Access

The experiences of Harris Wofford and Marjorie Margolies with the Pennsylvania electorate have been indelibly etched on the minds of legislators. Moreover, lest anyone forget the debacle of catastrophic health care reform several years ago, we should remember that Dan Rostenkowski was literally physically assaulted by elderly constituents who were angry that the catastrophic health care bill was potentially a drain on their resources—not an answer to their health care concerns. The legislation that was passed through monumental effort and compromise was even more quickly rescinded.

So despite all the rhetoric about health care reform, it is not clear that we will see sweeping changes. It should be remembered, however, that the driving force behind all discussions is concern about cost. In any discussions about the delivery of health care services the triad of cost, quality, and access are the three elements discussed. But it is concerns about costs—both personal costs and economic costs—that have fueled a desire to change the current system of health care.

In my view, the current concern about primary care and the need to expand the availability of primary care services is driven primarily by cost issues. There is the overriding belief that by expanding first-line health care service delivery—access to primary care services—the costs of health care will be held in check. Because cost and its relationship to access to primary care have been the most predominant components of any health care reform discussions, six different factors have emerged that will shape health care service delivery in general and nursing practice and education in particular.

The major changes evolving out of the health care reform debate are:

- Cost concerns will increase moves to managed competition models with or without national health care reform legislation.
- Increased use of competitive managed models will change service utilization patterns to continue the trends towards decreased length of stay.
- Increased calls for greater numbers of primary care providers will shift the nursing and medicine education patterns and create demands for new providers—new in both type and number.
- Large-scale workforce planning will create the need to make better workforce projections.
- Shifting care delivery patterns will redefine roles and turf for all health care professionals. This dynamic may increase the need for real interdisciplinary collaboration for education and practice.
- The brave new world of health care research may outstrip all of this planning with new treatment modes that will reshape our entire health care decision process.

I will discuss briefly each of these six items.

Costs and Managed Competition

First the issue of costs and managed competition. Without any kind of national reform legislation, increased use of cost competitive models of care delivery is occurring at the state level on a very widespread scale. The use of these models will have an effect on nursing practice and education. The states have been the most innovative and willing to make sweeping changes in response to their growing budget concerns. For several years now, the congress has sent the states unfunded legislative mandates to expand Medicaid coverage for uninsured pregnant women and children. The result has been a growing drain on state budgets. Witness the changes in a variety of states. Tennessee, Washington, Vermont, and Oregon have crafted plans to expand coverage through managed cost competitive models of care delivery.

In Washington State, a five year experiment of insuring low income residents was developed to expand coverage to the uninsured. Moreover, the plan focuses on primary and preventive care provided exclusively through managed care providers.

In Tennessee, the state developed TennCare—a program that most closely resembles the administration's plan. It is receiving widespread scrutiny by policy makers and loud and vocal opposition from physicians. A recent *Washington Post* report on TennCare indicated that Tennessee's experience with the massive bureaucratic apparatus that was necessary for enrolling 700,000 Tennessee residents has implications for the administration's proposed regional alliances.

In the Tennessee plan, the almost 3/4 million Tennessee residents who were previously served through state MEDICAID program are enrolled in twelve privately run health care networks in 13 regions of the state. Patients are required to receive their care through the managed care organizations. An additional 750,000 Tennessee residents who are not insured are also expected to enroll in these plans. Physicians' opposition to this plan is growing. The *Post* reported a very startling and horrifying story about one premature infant who died when the infant's mother was unable to locate a physician or service delivery site that would accept TennCare patients. Physicians complain loudly that the plan takes from them their control of their own practices and creates a nightmare of referrals to plan providers. But, the plan is having some of the desired effects by creating price competition for both physician services and hospital care.

This wide array of health care delivery changes is representative of the shifting ground upon which nursing must possibly rest its feet over the next decade. The effect of greater use of cost competition will be to create my second outcome—changes in service utilization patterns.

Utilization Patterns

The conventional wisdom for nursing is that employment in the acute care sector will decrease, the need for community-based nursing will increase, and advanced practice nursing will

increase. Advanced practice nursing will also need to expand in both numbers and roles as the effects of managed competition on employment in the acute care sector are realized. The recent nurse layoffs are an early indication of the changes. At a recent meeting of the Association of Academic Health Centers, a hospital CEO reported that his hospital had a 42 percent occupancy rate. I am told by nurse executives that this occupancy rate is not uncommon. It does not take long to know that 42 percent occupancy also equals decreased demand for nurses.

Only two years ago, nurse executives were reporting an increased nursing intensity demand for nurses in the acute care sector. The data most frequently cited reflected the increased demand for professional nursing expertise. Almost a decade ago, approximately 50 nurses were employed for every 100 hospital beds. Two years ago, nurse executives reported that the ratio was now over 90 nurses per every 100 beds, reflecting the growing intensity of patient care services. Today, however, we don't have data on the nurse to patient bed ratio, but we suspect that there have been dramatic changes downward. The growing discussions regarding the appropriate use of unlicensed assistive personnel, or patient focused care centers, are a result of what some nurse leaders feel is downward trend—in other words, a dumbing down of the workforce in the acute care sector. Whether or not our perception of this trend is accurate, we also must reflect on the changes in the delivery of services in the acute care setting. For example, approximately seven years ago, my father had quadruple coronary by-pass surgery. He was hospitalized for almost nine days. This year, the father of my staff member had the same surgery and was hospitalized for five days. Both had what, at best, can be termed noncomplicated routine CBGs.

In addition, recently we have heard reports about outpatient vaginal hysterectomy surgery, and there is growing use of laser cholecystectomy as the treatment of choice for cholelithiasis. Clearly, these trends mediate towards decreased demand for professional nursing staff. And all of these are a result of growing concerns about the cost of health care delivery and the need to place controls on them.

It is not just MEDICAID or MEDICARE insurers who are worried about cost—today everyone, from the third party insuring agencies, to the employers who support the majority of health care coverage is worried. The pressures are towards decreased utilization of resources and a concurrent decrease in the costs associated with care delivery.

New Providers

For nursing, the result of this ongoing reform is layoffs or decreased hiring. Those of us in nursing education are witnessing a return to the experiences of the early 80's when Diagnostic Related Groups (DRGs) were first instituted. I remember the early days of DRGs when the graduates of the program in which I taught could not get jobs and were often told that the jobs were only available for nurses with experience. The Catch 22 was that you could not get experience unless you got a job. Anecdotes suggest that employment opportunities are still available in a number of areas of the country. The reality, however, is that nurses are often loath to relocate for employment and often grow up, go to school, and work in the same geographic region or locale. I also am told that employers are preferentially hiring graduates of baccalaureate nursing programs over graduates of associate or diploma programs. This trend again is a repeat of a phenomenon that occurred when DRGs were instituted. Many individuals, including Linda Aiken, professor at the University of Pennsylvania School of Nursing, and Ellen Rudy, Dean of the University of Pittsburgh School of Nursing, firmly believe that the current downsizing in the acute care sector is a momentary blip on the employment horizon that will once again turn up when employers realize that nursing is their best protection against low quality outcomes in care delivery.

Whether nor not the downsizing will end, and increased employment opportunities for nurses in the acute care sector materialize, I do not believe we will return to the previous status quo. Rather, the employment roles of nurses will be markedly different. In fact, the changes are already occurring in some places and will continue to grow. I am speaking about use of the advanced practice nurse in the acute care sector. The newly emerging acute care nurse practitioner role or reshaped clinical nurse specialist role is perhaps the most dramatic change now occurring, and likely to continue, in the health care revolution. This clinical role is increasingly envisioned as the ultimate substitutive model. Nurses are substituting for physicians, most notably interns and residents, in acute care settings that are experiencing a downsizing of their training programs.

Better Workforce Projections

At a recent meeting of the Institute of Medicine (IOM) Roundtable on Academic Health Centers, it was reported, in fact, that at Sloan-Kettering Memorial Cancer Institute advanced practice nurses manage half the beds in the institution with residents managing the other half. At the University of Pittsburgh, the acute care nurse practitioner program is retraining clinical nurse specialists for this type of role. For nursing education, this trend demands a re-examination of the advanced practice education model. The traditional view of the advanced practice

nurse includes four categories of advanced practice nurses—the certified nurse midwife, the certified registered nurse anesthetist, the clinical nurse specialist, and the nurse practitioner. Some debate also occurs about the master's prepared nurse administrator and whether or not this individual is appropriately termed an *advanced practice nurse*.

The roles for certified nurse midwives and certified registered nurse anesthetists are fairly well delineated. Nurse practitioners and clinical nurse specialists, however, are increasingly being revisioned as providers of substitutive care. Nurse practitioners have represented, and continue to represent, a widely accepted model for advanced practice in primary care delivery settings. The shift that is occurring in the acute care setting is a reconceptualization of nurse practitioner practice that has raised serious questions about the education of nurse practitioners. Unfortunately, in some settings, the nurse practitioner educated for a primary care delivery role has been injected into the acute care delivery model without additional formal education or training about acute care. The nurse practitioner has been sought for several important reasons. First, nurse practitioners receive a more extensive education in clinical assessment and decision making, and clinical management, including pharmacotherapeutics. However, as an adult primary care nurse practitioner, I can tell you that I did not deal with issues related to management of the post-cardiac by-pass patient.

The result of this discontinuity between nurse practitioner education and the hospital's desire to employ these advanced practice nursing clinicians has been a growing trend either toward on-the-job training for acute care practice or toward development of acute care nurse practitioner programs. It is in fact the latter type of program that Ellen Rudy has developed at the University of Pittsburgh. Ironically, the third outcome of the current reform environment—calls to increase the number of primary care providers—will increase the need for acute care nurse practitioners.

Current discussions about the need to expand the primary care physician workforce which are a part of almost all health care reform proposals will increase the opportunities for the acute care nurse practitioner. As specialty, hospital-based residency training programs decrease in size, the resulting void will naturally be filled by the acute care nurse practitioner. The challenge to nursing education programs will be to craft a new curricular structure that will prepare this new acute care practitioner. Clearly, the conflict will be how to differentiate this role from the traditional clinical nurse specialist role.

To many individuals in nursing, there is some expectation that the traditional clinical nurse specialist role may disappear. This role has traditionally been viewed as a hybrid role—the administrator, clinician, researcher, educator rolled into one person. The secret will be to determine whether or not there is a niche for this clinician that the health care system either needs or will pay for. Unfortunately, in the view of many individuals, the clinical nurse specialist has not had the clinical expertise that is implied by the title. This is perhaps why the new acute care nurse practitioner role has emerged.

However, there is a role that may be appropriate for the clinical nurse specialist—that of the educator or case manager. At a recent meeting Phil Lee, Assistant Secretary of the Department of Health and Human Services, discussed the long-term issues for preparation of a health care workforce at large. He reported on a longitudinal study of diabetes management in which the health care team discerned that end stage disease complications in diabetes could be managed or prevented through aggressive management of diabetes. Dr. Lee met with the researchers in this longitudinal study and asked who the most important person in the team was. The answer was the *nurse educator*. Not the *nurse practitioner*, not the *physician*, *pharmacist*, or *podiatrist*. It was the *nurse educator* who spent time educating the clients about management and control of their chronic illness. What happens to this role in a health care system that mediates towards lower cost and faster exchange of services with the patient? It is not clear to me that this is an issue that has been well enough thought out in any reform debates. This is the quality issue that has been left untouched.

So what happens to the *clinical nurse specialist* role is an issue to be resolved. It is clear that there is tremendous interest in the traditional *nurse practitioner* role and the new acute care clinician who has gained a skill mix that is an evolutionary off-shoot of the traditional nurse practitioner role. And the nursing education system will need to expand production of these clinicians.

Currently, there is extensive expansion occurring in traditional and new nurse practitioner roles. Our organization has surveyed existing graduate nursing programs to identify the number, type, and production of nurse practitioner programs. We have found that there are over 300 nurse practitioner programs offered in over 100 institutions. In addition, we know that approximately 45 additional institutions plan to open new programs for nurse practitioners. Half of the existing nurse practitioners programs report having waiting lists with an average

of 21 names on them. The other programs do not have waiting lists. Not because they do not have individuals they cannot accommodate, but rather because they do not keep waiting lists. There are a number of reasons why qualified applicants cannot be accommodated. And you probably know these reasons as well as I do. First, there is a serious shortfall of faculty to teach these advanced practice clinicians. Second, there is growing competition with our physician counterparts for clinical training sites.

Competition for training sites is of growing concern. As the health reform discussions increasingly place pressures for larger production of a primary care workforce, medical educators have been aggressively moving to expand this type of clinical training activity. Unfortunately, the result is a closing out of nurse practitioner, certified nurse midwife, or certified registered nurse anesthetist students from these clinical training sites. Obviously, any efforts to expand production of these advanced practice nurses will require expansion of the clinical training activities. Moreover, there will also need to be some clearer articulation of the specific roles and competencies that these clinicians should have.

Redefinition of Roles and Turf

This concern—identification of role boundaries—will lead to two major changes in work roles and workforce planning. Currently, the American Medical Association and American Nurses Association have announced that they will hold discussions about role delineations and the appropriate parameters of nurse-physician practice. These discussions could produce extremely vital understandings about the overlap and differences between nurse and physician practice. Or these discussions could further delineate the serious gaps between these two professions' understanding of how care should or can be delivered. Clearly, the scope of health professional practice, in general, is becoming a very muddy issue. Pharmacy is an example of another discipline that can produce very good, primary care intervention. Some of the duties of a clinical pharmacist are very similar to either an MD's or nurse's scope of practice. So who is in charge of the care? And who should do what? These are the politically or ideologically charged questions that may never be answered. But these are issues that all health professionals should face.

In the best of all worlds, a logical response to these questions would be to define, in some fashion, the scope of care to be delivered. That is we could decide what the primary care need is for this country's population. Out of that decision would logically flow some discussion of the types of services that are necessary and who could provide them. This process is a component of current reform discussions. In reality, we currently have several public bodies that are making independent

assessments about the health care workforce, each of whom are making projections based upon their own professional expectations for need and their own professional concerns about turf. The public health service has had an advisory body on Nurse practitioners and certified nurse midwives workforce projections working for almost a year, and a preliminary report has been produced. Moreover, The Council on Graduate Medical Education has produced its own physician workforce projections.

The advisory group on physician assistant supply has also produced a report on the need for physician assistants to provide a range of primary care and other services. Logic would indicate to anyone familiar with the roles filled by these three disciplines that there should be a greater emphasis on interdisciplinary collaboration regarding workforce need than there is. In the view of some individuals in medical education, there are not only too many specialists produced in medicine, there are too many physicians being produced annually. This opinion is based in part on the belief that many specialists should be redirected to generalist practice and that the absolute volume of specialty services is a direct result of the number of specialty providers, not the result of the number of services needed.

Many medical educators are saying out loud that medical school student body size should be dramatically decreased and that those states or institutions that are attempting to open new programs should not be allowed to do so. If, in fact, the reform process were to redirect a significant portion of the current medical workforce towards primary care delivery, would we need as many nurse practitioners as we think we need? Nursing has lived and breathed shortage for decades. Our professional growth and support for nursing has been strongly based on assumptions of need, shortages, and old models of delivering nursing care. The reality today is that we may have adequate numbers of nurses. And, we may have too many of certain types of nurses and too many nursing programs. In fact, economic modeling projects that the supply of a wide variety of professionals is adequate to meet the need in a managed care environment.

One of the very major effects of health reform on nursing may be the need to define workforce supply in very different ways and therefore try to do some logical workforce management and planning. Would we in nursing have the courage to say out loud that there are too many nursing schools and too many graduates produced each year? The Clinton reform plan calls for a national body to do workforce planning. It seems to me that this is not an issue that will go away and that we will need to confront

issues related to the types and numbers of nurses who are produced annually.

Effects of Medical Research

Finally, I want to discuss the *You-ain't-seen-nothing* factor that I believe will drive future discussions about the delivery of health care. We stand at the brink of the brave new world of genetic engineering. What happens to health care delivery and our traditional ideas about how care is provided in a world in which genetic screening allows predictions with a high degree of certainty about an individual's future health or illness status? For instance, right now, the human genome project has identified a gene that produces breast cancer in 90% of individuals with that gene. Will we have a brave new world in which genetic screening will be the focus of care and not primary prevention or health promotion screening?

We will need to be ready for a health care decision-making process that may be very different than what we now know. The factors driving reform discussions do create marvelous challenge and opportunity for nursing. The challenge will be to educate our existing work force and the new practitioners of nursing about the forces defining care delivery. At a recent meeting of The Federation of the Associations of Schools of the Health Professions, Dick Knapp, Vice President for The American Association of Medical Colleges, announced that his organization has begun discussions with The Group Health Association of America about how to educate new MDs in a managed care environment and about managed care. Medical educators recognize that for at least the short-term future, cost factors will increase the use of competitive models of care delivery. In addition, many provider networks are forming to deliver cost competitive care without any federal or state mandates to do so.

Nurses must be educated about the cost issues associated with health care in general and nursing in particular. Moreover, nurses must use a cost-conscious decision process in delivering care. Our challenge is to provide nurses with the skills and knowledge to do this. Nurse researchers can provide an answer to many of the system's ills. The work of researchers like Dorothy Brooten is central to validating the quality and cost benefits of applying nursing's solutions to health care problems. Unfortunately, much of the research conducted by nurses is soft and does not inform us of the crititcal issues facing our profession. There must be an expansion of socially and professionally relevant research in nursing.

In the interim, reform discussions continue. I think it is clear that some kind of legislation will pass this year. It will be

difficult for legislators to return home without some package that they can display to their constituents. For nursing, we have the joy of being actively included in the process. From the beginning days of the Clinton Task Force on Health Care Reform to the present Congressional discussions about providers and health professions workforce development, nursing has been a visible and sought-after presence. Our challenge will be to continue that participation and to not stop worrying. My grandmother had a saying that worrying must work, because most of the things she worried about never happened. I think there is some truth to this adage because worrying is symbolic of our attention to issues. I have great hope that we will see significant improvements in the understanding of how nursing is central to a reformed health care system. And the fun—if we can call it that—will be *in the making of this sausage*.

SOUTHERN COUNCIL ON COLLEGIATE EDUCATION FOR NURSING
in affiliation with the Southern Regional Education Board
592 Tenth Street, N. W. ■ Atlanta, Georgia 30318-5790
404-875-9211

BEST COPY AVAILABLE